DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Disability and Elder Services
DDE-2092 (Rev. 4-04)

STATE OF WISCONSIN
Bureau of Quality Assurance

FOR OFFICE USE ONLY
COA No.
COA Fee
Caregiver Background Fee
Effective Date

HOSPITAL CERTIFICATE OF APPROVAL APPLICATION

TYPE OF APPLICATION
☐ Initial ☐ Change of Ownership

Completion of this form is required by s. 50.35 Wis. Stats., for hospitals. Failure to complete this form may result in non-issuance of a hospital certificate of approval. The personally identifiable information collected on this form will be used to determine licensure eligibility and for statistical information and for no other purpose. Collection of the applicant's social security number (SSN) or federal employer identification number (FEIN) is required by ch.50.498 Wis. Stats**.** Failure to supply the number may result in denial of the application. The number will be disclosed only to the Department of Revenue for use in collection of tax delinquencies.

Questions about completion of this application may be directed to the Provider Regulation and Quality Improvement Section at 608-266-7297.

I. GENERAL INFORMATION

A. HOSPITAL LOCATION

Name –Facility	Initial Begin Date (at present location)
Previous Hospital Name (if applicable)	
Street (physical) Address	
Mailing Address	

City	County	State	Zip Code
Telephone Number	FAX Number		
E-mail Address			

B. CHANGE OF OWNERSHIP

List the previous owner's name, Certificate of Approval (COA) number, and Medicare and Medicaid numbers.

Name – Previous Owner		
Previous COA Number	Medicare Number - Previous Owner	Medicaid Number - Previous Owner

C. TYPE OF HOSPITAL

- ☐ General
- ☐ Special
  - ☐ Chemical Dependency / Alcohol
  - ☐ Children's
  - ☐ Psychiatric
  - ☐ Rehabilitation
  - ☐ Maternity
  - ☐ Orthopedic
  - ☐ Surgical
- ☐ Critical Access Hospital (CAH)
- ☐ Long Term Acute Care
- ☐ Hospital Located Within Another Hospital
- ☐ Other (specify)

Name - Fiscal Intermediary	Fiscal Year End Date

D. TYPE OF CERTIFICATION

Applying for:

- ☐ Medicare (Title XVIII)
- ☐ Medicaid (Title XIX)
- ☐ Medicare and Medicaid
- ☐ State Licensed Only (no TXIX / TXVIII certification)

E. ACCREDITATION STATUS

- ☐ Non Accredited
- ☐ Applying for Accreditation With:
  - ☐ JCAHO
  - ☐ AOA
  - ☐ Program JCAHO
  - Other (specify):

Complete the following for CHANGE OF OWNERSHIP applications only:

☐ Currently Accredited By: ☐ JCAHO ☐ AOA ☐ Other	Accreditation Begin Date Accreditation End Date
☐ Deemed	Deemed Begin Date Deemed End Date

F. BED CAPACITY Indicate the total number of beds requested for those categories that apply

General Acute Beds	**BREAKDOWN**	
TOTAL Psychiatric Beds	Psychiatric Beds	*PPS Psychiatric Beds
TOTAL Rehabilitation Beds	Rehabilitation Beds	*PPS Rehabilitation Beds
Chemical Dependency / Alcohol Beds	*PPS (Prospective Payment System) excluded psychiatric and PPS excluded rehabilitation beds must have prior approval from the Centers for Medicare and Medicaid Services (CMS). If you are adding new PPS excluded psychiatric or rehabilitation beds, you must include a copy of the CMS approval letter with this application.	
TOTAL BEDS		

If Critical Access Hospital (CAH):

Swing Bed Approval ☐ Yes ☐ No	Acute Care Beds	Observation Beds	Total Beds

G. OFFSITE LOCATIONS ☐ Yes ☐ No

Name of Off-Site	Type of Provider
Physical Address	Telephone Number
City / State / Zip Code	Number of Beds

Services Provided

Name of Off-Site	Type of Provider
Physical Address	Telephone Number
City / State / Zip Code	Number of Beds

Services Provided

Name of Off-Site	Type of Provider
Physical Address	Telephone Number
City / State / Zip Code	Number of Beds

Services Provided

If a change of ownership or more offsite locations are being applied for, or have been approved by the Centers for Medicare and Medicaid Services (CMS), CHECK HERE ☐ and attach a separate listing. The listing should include all required information for each component, not located on the hospital's premises, that will be billed under the hospital's Medicare provider number and that will operate under the hospital's certificate of approval number. Also, describe the services that will be provided and the number of beds if overnight inpatient services will be provided. Provide a copy of CMS' approval letter for each offsite location.

H. SERVICES PROVIDED BY THE HOSPITAL

Check the types of services that will be provided. Attach additional pages if necessary. Place a "1" if the service will be provided directly by hospital staff and a "2" if the service will be provided by contracting with another provider of service. If services will be provided both directly and by contract, insert a "3."

Check if Provided	Enter 1, 2 or 3	Service
☐		Acute renal dialysis
☐		Alcohol and/or drug services
☐		Anesthesia services
☐		Blood bank
☐		Burn care unit
☐		Chiropratic services
☐		Coronary care unit
☐		Dental services
☐		Dietetic services
☐		Emergency services (organized)
☐		Home care program
☐		Hospice
☐		Inpatient surgical services
☐		Intensive care unit
☐		Laboratory services (clinical)
☐		Laboratory services (anatomical)
☐		Long term care unit
☐		Neonatal nursery
☐		Nuclear medicine services
☐		Obstetrics
☐		Occupational therapy services

Check if Provided	Enter 1, 2 or 3	Service
☐		Open heart surgery facilities
☐		Operating rooms
☐		Optometric services
☐		Organ bank
☐		Organ transplant services
☐		Outpatient services
☐		Outpatient surgery unit
☐		Pediatric services
☐		Pharmacy
☐		Physical therapy services
☐		Post-operative recovery rooms
☐		Psychiatric services
☐		Radiology services (diagnostic)
☐		Radiology services (therapeutic)
☐		Rehabilitation services
☐		Respiratory care services
☐		Self care unit
☐		Shock trauma
☐		Social services
☐		Speech pathology services
☐		Other (specify):

I. STAFFING Number of full-time **(FT)** and part-time **(PT)** employees.

	FT	PT		FT	PT
1. Chief Executive Officer			8. Pharmacy		
*2. Nurse Administrator, RN			9. Dietary		
*3. Nurse Supervisor			10. Laboratory		
*4. Registered Staff Nurses			11. Housekeeping		
*5. LPN Staff Nurses			12. Maintenance Personnel		
6. Nurse Aides			13. Laundry Personnel		
7. Medical Records			14. Other (Specify)		
			(Attach additional pages if necessary.)		

*Under 2, 3, 4, and 5, report only those registered or licensed nurses with a current registration or license number. Report all other nurses under number 6.

II. PLANT DESCRIPTION AND SPACE USE
(Not required for facilities that already have departmentally approved plans.)

A. Description of Facility [HFS 124.27, 42 CFR 485.623(a)]

ATTACH plans or drawings for each floor of the building occupied by the existing hospital and IDENTIFY:

1. Life Safety Code Plans

   (a) Exiting
   (b) Fire barriers
   (c) Smoke barriers
   (d) Horizontal exits
   (e) Exit passage ways
   (f) Vertical shafts
   (g) Linen and trash chutes, and
   (h) Additional relevant information.

2. Building Information

   (a) Construction type
   (b) Age of existing building segments
   (c) Additional relevant information
   (d) Local zoning compliance statement

3. Existing Space Description

   (a) Current room/space use
   (b) Identification of hazardous areas protected by rated fire resistive partitions
   (c) Other relevant information.

4. Proposed Use of Rooms / Space within the Hospital

5. ADA (Americans with Disabilities Act) Accessibility Plan

   (a) Parking
   (b) Access routes
   (c) Toilet rooms for public, staff and patients indicating if ADA accessible
   (d) Additional relevant information

Yes	No	Answer each of the following questions by checking the **"Yes"** or **"No"** boxes
☐	☐	**1**-a. Are building alterations and remodeling proposed? **1**-b. If **YES**, attach plans or drawings indicating the areas of remodeling. **SEE B.2.**
☐	☐	**2**-a. Will the building have a mixed occupancy? **2**-b. If **YES,** identify all classifications and locations on the drawings or plans requested above.
☐	☐	**3**-a. Has the JCAHO (Joint Commission on the Accreditation of Healthcare Organizations), or the State approved any Life Safety Code variances or waivers? **3**-b. If **YES**, attach a copy of the award letter and waivers that have been approved.

Yes	No	
☐	☐	**4**-a. Are all patients/clients/residents capable of leaving the building on their own?
☐	☐	**4**-b. If **NO**, are there instances when four (4) or more staff dependent patient/clients/residents are present in the building at the same time?
☐	☐	**5**. Is the building equipped with a fire alarm system?
☐	☐	**6**-a. Is there an interconnected smoke detection system? **6**-b. If **YES**, is the smoke detection system: ☐ Throughout the building, i.e., in all areas, common areas and work spaces, whether occupied or not. ☐ In limited areas. Identify locations on drawings.
☐	☐	**7**-a. Is there an approved and supervised automatic sprinkler system? **7**-b. If **YES**, is the automatic sprinkler system: ☐ Throughout the building, i.e., in <u>all</u> areas throughout the building. ☐ In limited areas. Identify locations on drawings.
ENTER NUMBER		**8**. Indicate the number of building stories:
		8-a. Above ground, including the exit level.
		8-b. Below the ground level of the exit.

B. PROPOSED USE OF IDLE SPACE

Use of idle space requires considerable study to determine how the facility can be sectioned-off for new services, renters, or types of uses, etc. The direction and scope of renovations must be in compliance with LIFE SAFETY CODES. Applicant is strongly urged to seek expert advice, e.g., an engineering consultant, to determine which space to declare idle. Renovation cost may be a factor to consider before applying for hospital licensure status.

1. Explain how you will utilize the idle space, e.g., rental to outside groups, expansion of outpatient services, integration of existing or new health care services. **(Attach narrative.)**

2. If applicable, provide a description of construction considerations and time frame for the renovations described in Table above. (**Attach <u>only one</u> narrative covering all proposed building changes.) NOTE:** You must contact the Bureau of Quality Assurance prior to initiating all physical plant and environment renovations.

Plan Approval Applications (form DDE-2333) can be obtained at http://dhfs.wisconsin.gov/forms/DDENum.asp or by calling (608) 243-2088**.**

III. ADMINISTRATION

A. HOSPITAL ADMINISTRATOR / CHIEF EXECUTIVE OFFICER (CEO)

Name - Administrator / CEO	☐ Male ☐ Female	Begin Date
Title	Status ☐ Interim ☐ Acting ☐ Permanent	

Is the Administrator / CEO in charge of more than one facility? ☐ Yes ☐ No

If Yes, Name of Facility and City	Type of Provider

1. EDUCATION

Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year

2. WORK EXPERIENCE

Employer	Position
Address	Dates

Attach a resume, and a copy of the professional license, if applicable, for the administrator, managing employee and medical director, which includes their educational and work experience.

B. PERSON IN CHARGE IN ABSENCE OF ADMINISTRATOR / CEO (SUBSTITUTE ADMINISTRATOR)

Name	Begin Date
Title	

1. EDUCATION

Name of School / College / University	Years Attended
Address	Diploma / Degree / Year
Name of School / College / University	Years Attended
Address	Diploma / Degree / Year

2. WORK EXPERIENCE

Employer	Position
Address	Dates

C. NURSE ADMINISTRATOR (DIRECTOR OF NURSING)

Name	Begin Date

D. NAME OF PERSON IN CHARGE OF EACH DEPARTMENT

Dietary Service	Medical Records

IV. OWNERSHIP

A. APPLICANT (OWNER) Person(s) or business entity having the authority to direct the management or policies of the facility.

Name – Applicant (owner)			FEIN or SSN
Street (physical) Address			
Mailing Address (if different from physical address)			
City	State	Zip Code	County
FAX Number	Telephone Number		
E-mail Address			
Contact Person			Telephone Number
Title – Contact Person			

Holding (what the owner owns): ☐ Operations ☐ Building ☐ Land

B. TYPE OF ORGANIZATION (Check type of ownership.)

GOVERNMENTAL	PROPRIETARY	VOLUNTARY NON-PROFIT
☐ City ☐ County ☐ State ☐ Federal ☐ City / County ☐ Tribal	☐ Sole Proprietary ☐ Partnership ☐ Corporation ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Trust	☐ Corporation ☐ Church ☐ Association ☐ Church / Corporation ☐ Private Non-Profit ☐ Limited Liability Company ☐ Limited Liability Partnership ☐ Trust
If Incorporated, Date Incorporated	**Attach a copy of the articles of incorporation, or if a foreign corporation, attach evidence of authority to do business in Wisconsin.**	

C. INTERESTED PARTIES List all names.

Definition: Interested parties are (1) persons or business entities having ownership interest of 5% or more, (2) partners if the entity is a partnership, (3) officers and directors if the entity is a corporation, and (4) if the entity is either governmental or non-profit, interested parties are the officers and directors. If there is a separate listing already in existence, and that listing contains all the required information, attach a copy of that listing to this application. If a complete listing is attached, completion of this portion of the application will be considered satisfied.

Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage

D. OTHER PROVIDERS THAT ARE LICENSED AND / OR MEDICARE CERTIFIED, LOCATED IN WISCONSIN, AND ARE OWNED OR OPERATED BY THE APPLICANT / OWNER UNDER THE EXACT SAME OWNER NAME.

If more than two, check here ☐ and attach additional pages.

Name – Provider		
City	State	Zip Code
Relationship Type (nursing home, home health agency, community based residential facility, hospital)		

Name – Provider		
City	State	Zip Code
Relationship Type (nursing home, home health agency, community based residential facility, hospital)		

E. SUBSIDIARY / PARENT INFORMATION

1. Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?

☐ Yes ☐ No
If Yes, provide the following information:

Legal Business Name – Parent Company		
DBA (Doing Business As)		
Type of Ownership		
Mailing Address		
City	State	Zip Code
Contact Person	Telephone Number	

2. Is the applicant affiliated with any subsidiaries in the health care field in this state or any other state?

☐ Yes ☐ No
If Yes, provide one of the following:

- Names and addresses of all subsidiaries owned by the parent company, in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Organizational chart exhibiting the legal business names and, if applicable, the dba name of all the subsidiaries currently owned by the parent company in the health care field in this state or any other state, (relationship type: nursing homes, home health agencies, hospices, hospitals, rehabilitation facilities, etc.)
- Complete annual report to shareholders.

F. CHAIN ORGANIZATION

Is the applicant under the control of a chain organization? ☐ Yes ☐ No

Chain organization is defined as multiple providers, and/or suppliers owned, leased, or through any other devises, controlled by a single business entity (defined as chain home office). Each entity in the chain may have a different owner but the "home office" maintains uniform procedures in each facility for handling utilization review, reimbursement, handling admissions, also maintains and controls centrally, provider/suppliers cost reports, etc.

In addition, a chain facility would not necessarily be a subsidiary of the parent corporation but the chain facility or facilities could be owned by different subsidiaries of the same corporate parent.

Name – Chain Organization

G. FIT AND QUALIFIED

The following information will be used to determine if the applicant meets the fit and qualified requirements under Chapter 50, Wis. Stats.:

1. Has the applicant been affiliated in the past five years with a hospice (HSP), a home health agency (HHA), a residential care facility, e.g., Community Based Residential Facility (CBRF), Adult Family Home (AFH), or a health care facility (HCF), e.g., hospital, nursing home or facility for the developmentally disabled in the State of Wisconsin or in any other state.

   ☐ Yes ☐ No

   IF THE ANSWER IS YES, complete all information in the section below. Use the facility abbreviations (in parenthesis) from above to identify the type of facility.

   IF THE ANSWER IS NO, complete only questions 4 –14 of this section.

Facility Name and Address	City and State	Type of Health Care Provider	Owner / Operator / Mgr. Vendor / Provider No.	Dates of Affiliation

2. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license or approval?

   ☐ Yes ☐ No

   If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to G.1. (above) for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

3. Has any adverse action initiated by a state or federal agency based on non-compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

☐ Yes ☐ No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to G.1. (above) for abbreviations for type of health care provider.

Facility Name and Address	City and State	Federal or State	Type of Health Care Provider	Type of Adverse Action	Effective Dates of Adverse Action

4. Has the applicant ever had a denial, suspension, enjoining or revocation of a health care provider license, in this state or any other state, as defined in s. 146.81 Wis. Stats., or any conviction for providing health care without a license?

☐ Yes ☐ No

If Yes, explain.

5. Has the applicant ever been convicted of a crime involving neglect or abuse of patients, or involved in assaultive behavior, wanton disregard for the health and safety of others, or any act of elder abuse under s. 46.90, Wis. Stats.

☐ Yes ☐ No

If Yes, explain.

6. Has the applicant ever been convicted of a crime related to the delivery of health care services or items?

☐ Yes ☐ No

If Yes, explain.

7. Has the applicant ever been convicted of a crime involving controlled substances under Ch. 161, Wis. Stats.?

☐ Yes ☐ No
If Yes, explain.

8. Has the applicant had any prior financial failure that resulted in bankruptcy or in the closing of a hospice, home health agency or an inpatient health care facility, e.g., nursing home or hospital, or the relocation of its patients or residents?

☐ Yes ☐ No
If Yes, explain.

9. Has the applicant/owner been adjudicated bankrupt?

☐ Yes ☐ No
If Yes, explain on a separate page. Provide the dates, court and disposition of each action.

10. Are there any unsatisfied judgements against the applicant/owner?

☐ Yes ☐ No
If Yes, explain on a separate page. Provide the names and addresses of creditors, amounts and the reasons for non-payment.

11. Does the applicant / owner owe any debts that are 90 days past due?

☐ Yes ☐ No
If Yes, explain on a separate page. Provide the names and addresses of creditors, amounts and reasons for non-payment.

12. Does the applicant / owner plan to provide care to patients who are unable to pay for service?

☐ Yes ☐ No

13. Attach proof of sufficient resources as may be necessary to operate the facility for at least 90 days. Proof of sufficient financial resources should include income / expense statements.

14. FINANCIAL REFERENCES
This question is to be completed by the APPLICANT. Include at least one bank.
Attach additional pages if necessary.

Name		Telephone Number
Address		
City	State	Zip Code

Name	Telephone Number
Address	
City / State / Zip Code	

H. OWNER OF BUILDING / LAND

If the building and / or land is owned by an entity, i.e., corporation, partnership, individual, etc., other than the applicant / owner, complete this section If owner of land is another entity, also complete Section I.

Holding: ☐ Building ☐ Land

Name		Telephone Number
Mailing Address	County	Fax Number
City	State	Zip Code

I TYPE OF ORGANIZATION (Check type of ownership)

GOVERNMENTAL	PROPRIETARY	VOLUNTARY NON-PROFIT
☐ City	☐ Sole Proprietary	☐ Corporation
☐ County	☐ Partnership	☐ Church
☐ State	☐ Corporation	☐ Association
☐ Federal	☐ Limited Liability Company	☐ Church / Corporation
☐ City / County	☐ Limited Liability Partnership	☐ Private Non-Profit
☐ Tribal	☐ Trust	☐ Limited Liability Company
		☐ Limited Liability Partnership
		☐ Trust

J. INTERESTED PARTIES List all names.

Definition: Interested parties are (1) persons or business entities having ownership interest of 5% or more, (2) partners if the entity is a partnership, (3) officers and directors if the entity is a corporation, and (4) if the entity is either governmental or non-profit, interested parties are the officers and directors. If there is a separate listing already in existence, and that listing contains all the required information, attach a copy of that listing to this application. If a complete listing is attached, completion of this portion of the application will be considered satisfied.

Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Street			Begin Date
City	State	Zip Code	Ownership Percentage

K. OWNER OF LAND

Complete this section if the owner of the land is not the same entity as the owner of the operation or the owner of the building.

Holding: ☐ Land

Name		Telephone Number
Mailing Address	County	Fax Number
City	State	Zip Code

L. TYPE OF ORGANIZATION (Check type of ownership)

GOVERNMENTAL	PROPRIETARY	VOLUNTARY NON-PROFIT
☐ City	☐ Sole Proprietary	☐ Corporation
☐ County	☐ Partnership	☐ Church
☐ State	☐ Corporation	☐ Association
☐ Federal	☐ Limited Liability Company	☐ Church / Corporation
☐ City / County	☐ Limited Liability Partnership	☐ Private Non-Profit
☐ Tribal	☐ Trust	☐ Limited Liability Company
		☐ Limited Liability Partnership
		☐ Trust

M. INTERESTED PARTIES List all names.

Definition: Interested parties are (1) persons or business entities having ownership interest of 5% or more, (2) partners if the entity is a partnership, (3) officers and directors if the entity is a corporation, and (4) if the entity is either governmental or non-profit, interested parties are the officers and directors. If there is a separate listing already in existence, and that listing contains all the required information, attach a copy of that listing to this application. If a complete listing is attached, completion of this portion of the application will be considered satisfied.

Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage
Name	Title		
Address			Begin Date
City	State	Zip Code	Ownership Percentage

IV. LEASE AGREEMENT

Is there a lease agreement? ☐ Yes ☐ No If "yes," list the name and address of the lease holder.

Name			
Mailing Address			
City	State	Zip Code	Lease Agreement End Date

V. MANAGEMENT COMPANY

A. Is the operation of the facility under a management contract? ☐ Yes ☐ No
If Yes, provide the following information regarding any management company retained to operate this facility or program.

Type of Management Company

☐ Corporation ☐ Partnership ☐ Individual ☐ Government

Name – Management Company		
Name – Contact Person	Telephone Number	
Address		
City	State	Zip Code

B. Identify officers, directors, trustees or supervisors of the management company.
Attach additional pages if necessary.

Name	Title	
Address		
City	State	Zip Code
Name	Title	
Address		
City	State	Zip Code

C. Identify other facilities the management company has owned, operated or managed in the last 5 years. Attach additional pages if necessary.

Name		
Address		
City	State	Zip Code
Dates of Involvement		
Name		
Address		
City	State	Zip Code
Dates of Involvement		
Name		
Address		
City	State	Zip Code
Dates of Involvement		

D. While managing any of the facilities identified in item C.:

1. Has any adverse action initiated by any state licensing agency resulted in the denial (D), suspension (S), or revocation (R) of a license?

☐ Yes ☐ No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to IV.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Owner / Operator / Mgr. Vendor / Provider No.	Dates of Affiliation

2. Has any adverse action been initiated by a state or federal agency based on non-compliance resulted in civil money penalties (CMP), termination of provider agreement (TPA), suspension of payments (SOP), or the appointment of temporary management of the facility (TMF)?

☐ Yes ☐ No

If Yes, please complete the following table. Use abbreviations to describe the type of adverse action and refer to IV.G.1. for abbreviations for type of health care provider.

Facility Name and Address	City and State	Type of Health Care Provider	Type of Adverse Action	Eff. Dates of Adverse Action

E. Attach a copy of the signed contract with the management company.

IV. CONTACT PERSON

Identify the person responsible for completing this application and who can be contacted if we have questions.

Name – Contact Person (print)		Title
Telephone Number	FAX Number	Date Application Completed

VII. DESIGNEE

Person authorized to accept personal service and receive registered and certified mail.

Is the administrator also the Designee? ☐ Yes ☐ No

If No, provide the following information:

Name – Designee	Title

State of Wisconsin

County of _____ Date _____

I swear or affirm that all statements made in this application, and any attachments thereto, are correct to the best of my knowledge and that I will comply with all laws, rules and regulations governing the licensing of Wisconsin facilities.

_____
Signature of Applicant's (Owner's) Legal Representative

The Management Company cannot attest to or sign on behalf of the applicant (Owner)

_____
Print Legal Representative's Name

_____
Legal Representative's Title

NOTARY SEAL

Subscribed and sworn to before me a Notary Public, in and or said State and County.

This _____ day of _____, _____.

My commission expires: _____

_____
Notary Public

RETURN THE COMPLETED AND NOTARIZED APPLICATION TO:
Bureau of Quality Assurance
Provider Regulation and Quality Improvement Section
PO Box 2969
Madison WI 53701-2969